

Subject: Studies in the News: (November 19, 2009)



Studies in the News for



California Department of Mental Health

Introduction to Studies in the News

Studies in the News (SITN): California Department of Mental Health is a service provided to the Department of Mental Health by the California State Library. This service features articles focusing on mental health issues. Prior lists can be viewed from the California State Library's Web site at [California State Library - Studies in the News](#)

Mental health articles and e-books are also available at the California State Library

How to Obtain Materials Listed in SITN:

- When available on the Internet, the URL for the full-text of each item is provided.
- **California State Employees** may contact the Information Resources and Government Publications section (916-654-0261; cslinfo@library.ca.gov) with the SITN issue date and title of article.
- All other interested individuals should contact their local library-the items may be available there, or may be borrowed by your local library on your behalf.

CONTENTS IN THIS ISSUE

BRAIN INJURY

[Children at low risk of brain injury after head trauma](#)

CHILDREN AND ADOLESCENTS

[Children's exposure to violence](#)

[School bullying among adolescents in the United States](#)

[Physical discipline and developmental outcomes](#)

CLINICAL

[Common mental disorder and obesity](#)

[Major depression and physical activity](#)

[Schizophrenia](#)

DISPARITIES

[Mental health disparities](#)

POLICY

[Evidence-based practice in community mental health agencies](#)

QUALITY

[Measuring mental healthcare quality in the United States](#)

[Quality of institutional care for people with longer term mental health problems](#)

QUALITY OF LIFE

[Working after retirement and mental/physical health](#)

[Green environment and mental health](#)

SUICIDE PREVENTION

[Coping with thoughts of suicide](#)

[Future oriented group training for suicidal patients](#)

TREATMENT

[Mental health support and self-help groups](#)

[CONFERENCES, MEETINGS AND WEBINARS](#)

BRAIN INJURY

“Identification of Children at Very Low Risk of Clinically-important Brain Injuries after Head Trauma.” By Nathan Kuppermann, University of California, Davis, School of Medicine, and others. IN: *The Lancet*, vol. 374, no. 9696 (October 2009) pp. 1160-1170.

[“We derived and validated prediction rules for ciTBIs [clinically important traumatic brain injuries] in a large, diverse population of children with minor head trauma,” state the authors. Traumatic brain injury is a leading cause of death and disability in children worldwide. CT scans (CTs) are the reference standard for rapid detection of traumatic brain injuries (TBIs). However, the risk of ciTBIs after minor head trauma should be balanced against the risks of ionizing radiation of CTs. Improved methods to assess head injuries in children and evidence-based use of CTs are research priorities. The article discusses results from a study to identify children at very low risk for ciTBI after blunt head trauma for whom CTs might be unnecessary.

The authors found that:

- * Of the 42,412 children eligible for analysis, 10,178 (25 percent) were under age 2.
- * CTs were obtained on 14,969 (35.5 percent) of the children, of whom 780 (5.2 percent) had TBIs on CT.
- * Of 42,412 children, 376 had ciTBIs, with similar percentages in both age groups and in derivation and validation populations. Of the 376 children with ciTBIs, 60 (15.9 percent) underwent neurosurgery, and 8 were intubated for more than 24 hours for TBI.
- * In the validation group for children under age 2, the prediction rule (normal mental status, no scalp hematoma except frontal, no loss of consciousness for 5 seconds or more, non-severe injury mechanism, no palpable skull fracture, and acting normally according to the parent) had a negative predictive value of 100 percent and sensitivity of 100 percent.
- * In the validation group for children ages 2 and older, the prediction rule (normal mental status, no loss of consciousness, no history of vomiting, non-severe injury mechanism, no clinical signs of basilar skull fracture, and no severe headache) had a negative predictive value of 99.95 percent and sensitivity of 96.8 percent.

‘Application of these rules could limit CT use, protecting children from unnecessary radiation risks,’ conclude the authors. They add, ‘these rules provide the necessary data to assist clinicians and families in CT decision making after head trauma.’” MCH Alert (October 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

CHILDREN AND ADOLESCENTS

Children’s Exposure to Violence: A Comprehensive National Survey. By David Finkelhor, Crimes against Children Research Center, University of New Hampshire, and others. (Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice, Washington, DC) October 2009. 12 p.

[“This Bulletin discusses the survey’s findings regard children’s direct and indirect exposure to specific categories of violence, how exposure to violence changes as children grow up, and the prevalence and incidence of multiple and cumulative exposures to violence. It also discusses the implications of the survey findings for policymakers, researchers, and practitioners who work with juvenile victims of violence.

The survey confirms that most of our society’s children are exposed to violence in their daily lives. More than 60 percent of the children surveyed were exposed to violence within the past year, either directly or indirectly (i.e., as a witness to a violent act; by learning of a violent act against a family member, neighbor, or close friend; or from a threat against their home or school) (for full details on these and other statistics cited in this Bulletin, see Finkelhor et al., 2009). Nearly one-half of the children and adolescents surveyed (46.3 percent) were assaulted at least once in the past year, and more than 1 in 10 (10.2 percent) were injured in an assault; 1 in 4 (24.6 percent) were victims of robbery, vandalism, or theft; 1 in 10 (10.2 percent) suffered from child maltreatment (including physical and emotional abuse, neglect, or a family abduction); and 1 in 16 (6.1 percent) were victimized sexually. More than 1 in 4 (25.3 percent) witnessed a violent act and nearly 1 in 10 (9.8 percent) saw one family member assault another. Multiple victimizations were common: more than one-third (38.7 percent) experienced 2 or more direct victimizations in the previous year, more than 1 in 10 (10.9 percent) experienced 5 or more direct victimizations in the previous year, and more than 1 in 75 (1.4 percent) experienced 10 or more direct victimizations in the previous year.”]

Full text at: <http://www.ncjrs.gov/pdffiles1/ojdp/227744.pdf>

[\[Back to Top\]](#)

“School Bullying among Adolescents in the United States: Physical, Verbal, Relational, and Cyber.” By Jing Wang, National Institutes of Health, and others. IN: Journal of Adolescent Health, vol. 45, no. 4 (October 2009) pp. 368-375.

Our results suggest that ‘positive parental behaviors protect adolescents from not only bullying others but also being bullied . . . [and] that friendship protects adolescents from being selected as targets of bullies,’ state the authors. Previous research indicates that parents and friends are two important sources of social influences associated with adolescent bullying and victimization. However, no studies have examined the roles of parents and friends across different forms of bullying, particularly cyber bullying. In addition, few national studies have been conducted to provide a valid estimation of prevalence of physical, verbal, relational, and cyber bullying by adolescents’ gender, age, and race and ethnicity in the United States. The article presents findings from a study to examine four forms of in-school bullying, with two main purposes: (1) to explore gender, age, racial, and socioeconomic differences in prevalence of each form of bullying among adolescents in grades 6 through 10 and (2) to examine the roles of parental support and number of friends on each form.

The authors found that

* The prevalence of involvement in bullying others, being bullied, or both (within the last 2 months) was 20.8 percent for physical, 53.6 percent for verbal, 51.4 percent for

relational, and 13.6 percent for cyber.

* Compared with girls, boys were more likely to be involved in physical (bullies, victims, or bully-victims) and verbal forms (bully-victims), but less likely to be involved in relational forms (victims or bully-victims). For cyber bullying, boys were more likely to be bullies, whereas girls were more likely to be victims.

* Compared with white adolescents, African-American adolescents were more involved in bullying perpetration (physical, verbal, and cyber), but less involved in victimization (verbal and relational).

* More parental support was negatively associated with involvement in bullying across all four forms.

* Number of friends was related to involvement in all three traditional forms (physical, verbal, relational) but was not related to cyber bullying. For physical, verbal, and relational bullying, adolescents with more friends were more likely to be bullies but less likely to be victims, and, with the exception of physical bullying, they were also less likely to be bully-victims.

‘Our results confirmed the important roles of parental support and number of friends, and suggest that demographic characteristic as well as different forms of bullying should be considered when examining or planning interventions on adolescent bullying,’ conclude the authors.” MCH Alert (October 9, 2009)]

Full text at: <http://download.journals.elsevierhealth.com/pdfs/journals/1054-139X/PIIS1054139X09001384.pdf>

[\[Back to Top\]](#)

“Trajectories of Physical Discipline: Early Childhood Antecedents and Developmental Outcomes.” By Jennifer E. Lansford, Duke University, and others. IN: *Child Development*, vol. 80, no. 5 (September/October 2009) pp. 1385-1402.

[“The study explores how discipline changes during childhood and adolescence, and what family factors affect those changes. They conclude that when parents use physical discipline through childhood, their children experience more behavior problems in adolescence.

Using data collected in two longitudinal studies—one of almost 500 children who were followed from ages 5 to 16, the other of more than 250 children followed from ages 5 to 15—the researchers sought to answer questions of how discipline changes during childhood and adolescence, and whether there are factors within families and children that are associated with these changes.

They find that parents typically adjust the way they discipline their children in response to their children's growing cognitive abilities, using less physical discipline (spanking, slapping, hitting with an object) over time. As children grow older, physical discipline becomes less developmentally appropriate. However, when parents' use of physical discipline continues through childhood, by the time their children are teens, they're more likely to have behavior problems. Teens of parents who stop using physical discipline when their children are young are less likely to have these behavior problems.

‘Given these findings, mental health specialists and others who work with families should encourage parents to refrain from using physical discipline,’ according to Jennifer E. Lansford, associate research professor with the Social Science Research Institute and Center for Child and Family Policy at Duke University, who led the study. ‘They should also help parents—especially mothers who are at high risk of using harsh physical discipline because they have children whose behavior is challenging or they are dealing with a lot of stress in their environment—come up with alternate strategies for disciplining their children.’

‘Low income, low educational attainment, single parenthood, family stress, and living in a dangerous neighborhood form a constellation of risk that increases the chances that parents will continue to use physical discipline with their children,’ Lansford adds.

‘Parents are also more likely to continue using physical discipline with children who behave aggressively.’” Eureka Alert (September 15, 2009)] **Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

CLINICAL

“Common Mental Disorder and Obesity - Insight from Four Repeat Measures over 19 Years: Prospective Whitehall II Cohort Study.” By Mika Kivimaki, University College, London, England, and others. IN: BMJ, vol. 62 (2009) 8 p.

[“*Objectives:* To examine potential reciprocal associations between common mental disorders and obesity, and to assess whether dose-response relations exist.

Design: Prospective cohort study with four measures of common mental disorders and obesity over 19 years (Whitehall II study).

Setting: Civil service departments in London.

Participants: 4363 adults (28% female, mean age 44 years at baseline).

Main outcome: Common mental disorder defined as general health questionnaire ‘caseness;’ overweight and obesity based on World Health Organization definitions.

Results: In models adjusted for age, sex, and body mass index at baseline, odds ratios for obesity at the fourth screening were 1.33 (95% confidence interval 1.00 to 1.77), 1.64 (1.13 to 2.36), and 2.01 (1.21 to 3.34) for participants with common mental disorder at one, two, or three preceding screenings compared with people free from common mental disorder (P for trend<0.001). The corresponding mean differences in body mass index at the most recent screening were 0.20, 0.31, and 0.50 (P for trend<0.001). These associations remained after adjustment for baseline characteristics related to mental health and exclusion of participants who were obese at baseline. In addition, obesity predicted future risk of common mental disorder, again with evidence of a dose-response relation (P for trend=0.02, multivariable model). However, this association was lost when people with common mental disorder at baseline were excluded (P for trend=0.33).

Conclusions: These findings suggest that in British adults the direction of association between common mental disorders and obesity is from common mental disorder to increased future risk of obesity. This association is cumulative such that people with chronic or repeat episodes of common mental disorder are particularly at risk of weight gain.”]

Full text at: http://www.bmj.com/cgi/reprint/339/oct06_2/b3765

[\[Back to Top\]](#)

“A Longitudinal Community Study of Major Depression and Physical Activity.” By Scott B. Patten, University of Calgary, and others. IN: General Hospital Psychiatry (available online on September 16, 2009)

[“*Background:* The objective of this study was to determine whether major depressive episodes (MDEs) are associated with transitions between active and inactive recreational activity patterns.

Methods: The data source was the Canadian National Population Health Survey (NPHS). The NPHS included a brief instrument to assess MDEs and collected data on participation in recreational activities. In order to meaningfully categorize participation in recreational activities, the participation data was translated into overall estimated metabolic energy expenditure. A threshold of 1.5 kcal/kg per day was used to distinguish between active and inactive activity patterns. Proportional hazards models were used to compare the incidence of inactivity in initially active respondents with and without MDE and to compare the frequency of becoming active among initially inactive respondents with and without MDE.

Results: For active respondents with MDE, an elevated risk of transition into an inactive pattern was observed [adjusted hazard ratio (HR)=1.6; 95% CI 1.2–1.9]. However, MDE did not affect the probability of moving from an inactive to an active lifestyle (adjusted HR=1.0; 95% CI 0.78–1.19).

Conclusions: Major depressive episodes are associated with an increased risk of transition from an active to an inactive pattern of activity.”] **Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

Schizophrenia. By the National Institute of Mental Health. (The Institute, Bethesda, Maryland) 2009. 22 p.

[“Schizophrenia is a chronic, severe, and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness.

People with the disorder may hear voices other people don’t hear. They may believe other people are reading their minds, controlling their thoughts, or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated. People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking.

Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help. Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives. However, many people with schizophrenia can lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of schizophrenia. In the years to come, this work may help prevent and better treat the illness.”]

Full text at: <http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booket-2009.pdf>

[\[Back to Top\]](#)

DISPARITIES

“Mental Health Disparities.” By Marc A. Safran, Centers for Disease Control and Prevention, Atlanta, Georgia, and others. IN: American Journal of Public Health, vol. 99, no. 11 (November 2009) pp. 1962-1966.

[“Mental health disparities have received increased attention in the literature in recent years. After considering 165 different health disparity conditions, the Federal Collaborative for Health Disparities Research chose mental health disparity as one of four topics warranting its immediate national research attention. In this essay, we describe the challenges and opportunities encountered in developing a research agenda to address mental health disparities in the United States. Varying definitions of mental health disparity, the heterogeneity of populations facing such disparity, and the power, complexity, and intertwined nature of contributing factors are among the many challenges. We convey an evolving interagency approach to mental health disparities research and guidance for further work in the field.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

POLICY

“Implementing Evidence-based Practice in Community Mental Health Agencies: A Multiple Stakeholder Analysis.” By Gregory A. Aarons, University of California, San Diego, and others. IN: American Journal of Public Health, vol. 99, no. 11 (November 2009) pp. 2087-2095.

Objectives: We sought to identify factors believed to facilitate or hinder evidence-based practice (EBP) implementation in public mental health service systems as a step in developing theory to be tested in future studies.

Methods: Focusing across levels of an entire large public sector mental health service system for youths, we engaged participants from 6 stakeholder groups: county officials, agency directors, program managers, clinical staff, administrative staff, and consumers.

Results: Participants generated 105 unique statements identifying implementation barriers and facilitators. Participants rated each statement on importance and changeability (i.e., the degree to which each barrier or facilitator is considered changeable). Data analyses distilled statements into 14 factors or dimensions. Descriptive analyses suggest that perceptions of importance and changeability varied across stakeholder groups.

Conclusion: Implementation of EBP is a complex process. Cross-system-level approaches are needed to bring divergent and convergent perspectives to light. Examples include agency and program directors facilitating EBP implementation by supporting staff, actively sharing information with policymakers and administrators about EBP effectiveness and fit with clients' needs and preferences, and helping clinicians to present

and deliver EBPs and address consumer concerns.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

QUALITY

“Measuring Mental Healthcare Quality in the United States: A Review of Initiatives.” By Benjamin J. Herbstman and Harold A. Pincus. IN: *Current Opinion in Psychiatry*, vol. 22, no. 6 (November 2009) pp. 623-630.

[“Purpose of review: This review article aims to present a systematic overview of the current initiatives assessing mental and/or substance use (M/SU) healthcare quality in the United States.

Recent findings: The study found 36 initiatives incorporating M/SU indicators with efforts from the federal and state government, health plans, nongovernmental and professional organizations.

Summary: Although there has been much activity in recent years in the development of M/SU indicators, efforts have lacked coordination, have focused on limited areas of clinical activity, and have not been clearly linked to quality improvement activity. The study recommends that the United States government forms an entity to better coordinate efforts and address these concerns. Clinicians and provider organizations should also increase the use of already developed M/SU indicators to improve quality of care delivered.”] **NOTE: Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

“A Systematic Review of the International Published Literature Relating to Quality of Institutional Care for People with Longer Term Mental Health Problems.” By Tatiana L. Taylor, UCL Medical School, U.K., and others. IN: *BMC Psychiatry*, vol. 9, no. 55 (published online on September 7, 2009) 79 p.

[“*Background:* A proportion of people with mental health problems require longer term care in a psychiatric or social care institution. However, there are no internationally agreed quality standards for institutional care and no method to assess common care standards across countries. We aimed to identify the key components of institutional care for people with longer term mental health problems and the effectiveness of these components.

Method: We undertook a systematic review of the literature using comprehensive search terms in 11 electronic databases and identified 12,182 titles. We viewed 550 abstracts, reviewed 223 papers and included 110 of these. A ‘critical interpretative synthesis’ of the evidence was used to identify domains of institutional care that are key to service users’ recovery.

Results: We identified eight domains of institutional care that were key to service users’ recovery: living conditions; interventions for schizophrenia; physical health; restraint and seclusion; staff training and support; therapeutic relationship; autonomy and service user involvement; and clinical governance. Evidence was strongest for specific interventions

for the treatment of schizophrenia (family psychoeducation, cognitive behavioral therapy (CBT) and vocational rehabilitation).

Conclusion: Institutions should, ideally, be community based, operate a flexible regime, maintain a low density of residents and maximize residents' privacy. For service users with a diagnosis of schizophrenia, specific interventions (CBT, family interventions involving psychoeducation, and supported employment) should be provided through integrated programs. Restraint and seclusion should be avoided wherever possible and staff should have adequate training in de-escalation techniques. Regular staff supervision should be provided and this should support service user involvement in decision making and positive therapeutic relationships between staff and service users. There should be clear lines of clinical governance that ensure adherence to evidence-based guidelines and attention should be paid to service users' physical health through regular screening.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-9-55.pdf>

[\[Back to Top\]](#)

QUALITY OF LIFE

“Bridge Employment and Retirees’ Health: A Longitudinal Investigation.” By Yujie Zhan, University of Maryland, and others. IN: Journal of Occupational Health Psychology, vol. 14, no. 4 (October 2009) pp. 374-389.

[“Retirees who transition from full-time work into a temporary or part-time job experience fewer major diseases and are able to function better day-to-day than people who stop working altogether, according to a national study. And the findings were significant even after controlling for people's physical and mental health before retirement. The study's authors refer to this transition between career and complete retirement as ‘bridge employment,’ which can be a part-time job, self-employment or a temporary job....

‘Given the economic recession, we will probably see more people considering post-retirement employment,’ said co-author Mo Wang, PhD, of the University of Maryland. ‘These findings highlight bridge employment's potential benefits.’

‘Rather than wanting to work in a different field, they may have to work,’ said Wang. ‘In such situations, it's difficult for retirees to enjoy the benefits that come with bridge employment.’ The authors suggest that, when possible, retirees carefully consider their choice of post-retirement employment.

‘Choosing a suitable type of bridge employment will help retirees transition better into full retirement and in good physical and mental health,’ said co-author Kenneth Shultz, California State University, San Bernardino, adding that employers who are concerned about a labor shortage due to numerous baby boomers retiring might consider bridge employment options for their retirees.” American Psychological Association (October 13, 2009)]

Full text at: <http://www.apa.org/journals/releases/ocp-14-4-374.pdf>

[\[Back to Top\]](#)

“Morbidity is Related to a Green Living Environment.” By Jolanda Maas, EMGO Institute VU University Medical Centre, Netherlands, and others. IN: Journal of Epidemiology and Community Health (published online on October 15, 2009.)

[“People who live in green environs may be less likely than those surrounded by concrete to suffer a range of health problems, particularly depression and anxiety, according to a new study.

Researchers found that among more than 300,000 Dutch adults and children, those living near more ‘green spaces’ tended to have lower rates of 15 different health conditions.

The link was especially strong when it came to depression and anxiety, suggesting, the researchers say, that respite from stress and the hustle and bustle of urban life may be an important for reason for the benefits of green.

Past studies have found that people who live in greener environments tend to report better subjective health. But this study is the first to use objective data on specific mental and physical health diagnoses, lead researcher Dr. Jolanda Maas, of the VU University Medical Center in Amsterdam, told Reuters Health in an email.

The findings build on evidence that green space has a positive effect on health and is ‘more than just a luxury good,’ Maas said.

The strongest connection was seen with depression and anxiety. Among people who lived in areas with 90 percent green space, for example, just over 2 percent had been diagnosed with depression, compared with just over 3 percent of those living in areas with 10 percent green.

The study also found that the relationship between green space and health was particularly strong among children and lower-income groups, which, the researchers speculate, could be because they tend to spend much of their time close to home.”

Reuters (October 20, 2009)] **NOTE: Please contact the California State Library for a paper or electronic copy of this article**

[\[Back to Top\]](#)

SUICIDE PREVENTION

“Coping with Thoughts of Suicide: Techniques Used by Consumers of Mental Health Services.” By M.J. Alexander, Nathan S. Kline Institute, Orangeburg, New York, and others. IN: Psychiatric Services, vol. 60, no. 9 (September 2009) pp. 1214-1221.

[“People who live with mental illness and cope with thoughts of suicide have sent the suicide prevention field a new message to help guide our work. A convenience sample of 205 consumers of public mental health services in a wide variety of cities and rural counties in New York State was recruited through flyers placed in peer-operated settings offering a variety of services, including housing and peer drop-in. The flyers invited consumers who had previously attempted suicide ‘to participate in a Hope Dialogue...to examine techniques that individuals used to prevent a slide into darkness and despair.’ The participants completed a survey regarding available supports and responded to this question: ‘If your darkness and despair escalated to actual thoughts of suicide, what has helped you in the past to not take that action?’ Analysis of the responses produced 16

categories. The three most common strategies were spirituality and religious practices (18 percent), talking to someone and companionship (14 percent), and positive thinking (13 percent), together totaling 45 percent. These coping strategies were observed to mitigate hopelessness, isolation, and despair, all key risk factors for suicide. Using the mental health system (12 percent) was the fourth most common response. This work appears to be the first systematic attempt to find out from survivors of a suicide attempt what they find most helpful in managing their own suicidal thoughts. According to the study's authors, 'Nowhere do key vision statements for suicide prevention acknowledge the importance of shared communities of meaning—self-help and mutual-support groups, for example—that people with mental illness construct, operate, and use. This study's results indicate that religious beliefs and practices, companionship, and a social network of family and peers are key coping strategies for people with a history of attempted suicide.' Further analysis of the qualitative findings in the study revealed that the aspect of the mental health system that was most helpful in managing suicidal thoughts was a 'strong, enduring, mutually trusting' relationship between the consumer and a therapist. 'Other aspects of the formal mental health system, such as emergency services or crisis hotlines, were not preferred,' stated the authors. These findings should inform the development of crisis services for suicidal consumers as part of an overall suicide prevention approach. For instance, a response system that was truly designed to satisfy the needs of consumers in crisis would focus on providing spiritual and peer support, 'hopeful, respectful listening and support, and collaborative treatment decisions.' The authors conclude that 'suicide prevention initiatives must acknowledge peers, families and spiritual networks as key frontline responders to suicidal crises and provide them tools, training, and access to allow them to be sources of solace and hope in ways that indeed are responsive to lived experience.'" **Please contact the California State Library for a paper or electronic copy of this article.**

[\[Back to Top\]](#)

“Future Oriented Group Training for Suicidal Patients: a Randomized Clinical Trial.” By Wessel van Beek, EMGO Institute for Health and Care Research, Amsterdam, The Netherlands, and others. IN: *BMC Psychiatry*, vol. 9, no. 65 (October 7, 2009) 29 p.

[*Background:* In routine psychiatric treatment most clinicians inquire about indicators of suicide risk, but once the risk is assessed not many clinicians systematically focus on suicidal thoughts. This may reflect a commonly held opinion that once the depressive or anxious symptoms are effectively treated the suicidal symptoms will wane.

Consequently, many clients with suicidal thoughts do not receive systematic treatment of their suicidal thinking. There are many indications that specific attention to suicidal thinking is necessary to effectively decrease the intensity and recurrence of suicidal thinking. We therefore developed a group-training for patients with suicidal thoughts that is easy to apply in clinical settings as an addition to regular treatment and that explicitly focuses on suicidal thinking. We hypothesize that such an additional training will decrease the frequency and intensity of suicidal thinking. We based the training on cognitive behavioral approaches of hopelessness, worrying, and future perspectives, given the theories of Beck, McLeod and others, concerning the lack of positive

expectations characteristic for many suicidal patients. In collaboration with each participant in the training individual positive future possibilities and goals were challenged.

Methods: We evaluate the effects of our program on suicide ideation (primary outcome measure). The study is conducted in a regular treatment setting with regular inpatients and outpatients representative for Dutch psychiatric treatment settings. The design is a RCT with two arms: TAU (Treatment as Usual) versus TAU plus the training. Follow up measurements are taken 12 months after the first assessment.

Discussion: There is a need for research on the effectiveness of interventions in suicidology, especially RCT's. In our treatment program we combine aspects and interventions that have been proven to be useful in the treatment of suicidal thinking and behavior.”]

Full text at: <http://www.biomedcentral.com/content/pdf/1471-244x-9-65.pdf>

[\[Back to Top\]](#)

TREATMENT

Mental Health Support and Self-help Groups. By the Substance Abuse and Mental Health Services Administration, Office of Applied Studies. The NSDUH Report. (The Office, Rockville, Maryland) October 8, 2009. 4 p.

[“There has been an increasing awareness of the role that mental health support and self-help groups play in recovery from mental illnesses. Mental health support and self-help groups, historically considered as an alternative to traditional mental health treatment, are now recognized as partners in the continuum of mental health care.¹ The National Survey on Drug Use and Health (NSDUH) gathers information that can help provide a better understanding of the extent to which these groups are used, the characteristics of the people who use them, and the relationship between the more traditional modes of mental health treatment and mental health support or self-help groups. This issue of The NSDUH Report examines the characteristics of adults (i.e., persons aged 18 or older) who received treatment, counseling, or support for emotions, nerves, or mental health in the past year from an in-person support or a self-help group (support and self-help groups hereafter are referred to collectively as self-help groups). All findings presented in this report are annual averages based on combined 2005 to 2008 NSDUH data.”]

Full text at:

<http://www.drugabusestatistics.samhsa.gov/2k9/161/161MHSupportGroupHTML.pdf>

[\[Back to Top\]](#)

CONFERENCES, MEETINGS AND WEBINARS

American Academy of Addiction Psychiatry 20th Annual Meeting & Symposium

December 3-6, 2009
Los Angeles, California

For more information and registration: <http://www2.aaap.org/meetings-and-events/annual-meeting?phpMyAdmin=H6N%2CWzwzCJE-qgHtALaDla7GNj5>

National Federation of Families for Children's Mental Health's 20th Annual Conference

December 3-6, 2009
Washington, DC

For more information and registration: <http://www.ffcmh.org/conference/conference.html>

The Chadwick Center for Children and Families: 24th Annual San Diego International Conference on Child and Family Maltreatment

January 25-29, 2009
San Diego, California

For more information and registration: <http://www.chadwickcenter.org/conference.htm>

[\[Back to Top\]](#)